APPENDIX K

Regional Crisis Stabilization Protocols

MENTAL RETARDATION PROTOCOL
WESTERN STATE HOSPITAL
CENTRAL VIRGINIA TRAINING CENTER
&
HPR I

The intent of the Mental Retardation (MR) Protocol is to assure that patients with Mental Retardation receive the services that they need. The Protocol may indicate the need for inpatient psychiatric hospitalization but it may also mean that the patient may require more extensive MR services, which most psychiatric hospitals do not provide. The goal of this protocol is to secure the best services for the patient, as well as to make the Mental Retardation and Mental Health service providers team together to provide these services.

In order for an MR client to be admitted to our facility, both the MR Case Manager and the MH Case Manager or Emergency Services must agree that the client requires hospitalization. The client must come on a Temporary Detention Order (TDO) within forty eight (48) hours of a TDO being issued. A hearing is held to determine if the client meets criteria for commitment for inpatient psychiatric care. The Case Manager or representative from the Community Services Board (CSB) must attend this Hearing.

From time of admission until the time of Hearing, a team staffing on the Acute Admissions ward is held to determine if the client requires hospitalization for mental illness. A call for consultation is made with Central Virginia Training Center (CVTC) and the CSB. If it is determined that the patient requires inpatient psychiatric services, the client must be committed in order to receive these services. If it is determined by the treatment team that the patient does not require inpatient treatment for mental illness, the CSB is expected to find appropriate placement for the patient the day of the hearing or as soon as possible thereafter. The CSB is given this information as soon as the treatment team meets in order to facilitate placement. If no placement is available and the patient meets the criteria for commitment, he/she will be committed for a short period, as appropriate, so that adequate placement can be found.

If the patient is committed, a community/hospital Prescription Team meeting must be held within ten working days to formulate and discuss an effective treatment/discharge plan. This meeting will include everyone involved with the client, WSH staff, CSB Case Managers, CVTC staff and other possible placement providers.

If CVTC is recommended and the patient is accepted for admission there, transfer will occur immediately. A Judicial Certification hearing may be held at WSH prior to transfer to CVTC or the patient may be admitted to CVTC as an emergency respite admission under (37.1-65.2), as appropriate.

THE MR/MI PROTOCOL SHALL INCLUDE A DIAGNOSTIC TEAM:

The Diagnostic Team is chaired by the MR Protocol Specialist and may include a Clinical Social Worker, Psychologist, Psychiatrist, Program Manager, Team Leader, Mental Health Worker and Nursing staff. This team will be available for consultation within the community on issues pertinent to the Dually Diagnosed MR/MI population. Specifically, issues dealing with Hospital admissions vs Training Center admissions. This team is also available for behavioral treatment planning and consultation in order to keep a client maintained within the community. This may also, and is preferred, in conjunction with CVTC staff. The MR Specialist is also available for Prescription Team meetings with the CSB regions to discuss clients that are not currently in need of inpatient services, but have behavioral and mental deficits.

In addition, the protocol is to be used to help facilitate discharge for patients that are ready to leave the hospital, but need more community involvement. The MR Specialist will attend Treatment Team Meetings and Judicial Hearings when appropriate to help facilitate this involvement and to be a representative for the facility in these proceedings.

THE PROTOCOL IN REVERSE:

The Protocol is also used to assist CVTC with patients that need psychiatric inpatient treatment. This occurs when a patient's mental illness is the primary factor stopping discharge to the community. The patient is assessed and interviewed at CVTC. The information is taken back to WSH and discussed with the Director of Admissions and the Medical Director. Once admission is approved the patient will be committed to WSH and placed on Special Hospitalization for CVTC. CVTC staff along with CSB staff will attend staffing as appropriate. If possible, the client can be discharged to the community from WSH or will return to CVTC once his or her psychiatric condition is stable.

Revised 10/15/95

PROTOCOL FOR PROVIDING EMERGENCY PSYCHIATRIC HELP TO CITIZENS WITH MENTAL RETARDATION APPROVED BY THE NORTHERN VIRGINIA ASSOCIATION OF COMMUNITY SERVICES BOARDS

December 15, 1995

I. Purpose of Protocol

The purpose of this protocol is to establish procedures for helping citizens with a primary diagnosis of mental retardation (referred to hereafter as consumers) who are a danger to themselves or others' or are unable to care for themselves due to a mental illness.

II. Covered persons and circumstances

This protocol applies to consumer residents of Arlington, Fairfax, Prince William or Loudoun Counties or the Cities of Alexandria, Fairfax, Falls Church, Manassas or Manassas Park who are exhibiting symptoms consistent with mental illness.

III. Emergency screening

A. The emergency service of the community services board (referred to hereafter as CSB) in the consumer's county or city shall be responsible for screening. Consumers shall receive emergency psychiatric screening in the same manner as all other citizens of the jurisdiction.

B. If the emergency service staff find that the consumer is a danger to him/herself or others or is unable to care for him/herself due to a mental illness the emergency service staff shall contact the mental retardation case manager or equivalent (e.g., on-call supervisor).

C. If the emergency service staff determines that the consumer needs psychiatric hospitalization, has not been adjudicated incompetent and consents to hospitalization, the emergency service staff arranges for hospitalization. If the consumer has been adjudicated incompetent and the consumer's guardian consents to hospitalization, the emergency service staff arranges for hospitalization.

D. If the emergency service staff determines that the consumer needs psychiatric hospitalization and does not consent, is not able to give consent or if the guardian will not or cannot give consent; the consumer with mental retardation shall be detained in accordance with the Code of the Commonwealth of Virginia.

E. If the emergency service staff determines that consumer does not need psychiatric hospitalization, the emergency service worker shall help the consumer and/or the consumer's care giver to obtain medication, advice and follow-up recommendations, as appropriate.

F. If the consumer is not detained and the consumer, the care giver and/or the mental retardation case manager do not agree with the disposition proposed by emergency service staff, the mental retardation case manager shall follow his/her CSB's procedures for resolving differences in clinical judgements.

The supervisors or the mental retardation director shall attempt to resolve the disagreement. If they are unable to do so, the disagreement shall be referred to the heads of the agencies which employ the disagreeing parties. If the consumer/guardian disagrees, the matter is appealed to the CSB director.

2. There shall be resolution of the disagreement within 10 days of the initial appeal. The consumer may remain in the hospital during the appeal process.

ADMISSION PROCEDURE FOR INDIVIDUALS WITH MENTAL ILLNESS/MENTAL RETARDATION IN CRISIS

HPR III

PRESCREENING

1 When an individual is in crisis in the community, the Prescreening process will include a consultation between the CSB mental health professional and the CSB mental retardation professional to discuss needed services and local options. If this consultation cannot occur, this will not preclude admission to Southwestern Virginia Mental Health Institute (SWVMHI).

2. If community services are not available then the prescreening process would include a consultation between Unit Director or designee from SWVMHI and the CSS prescreener to discuss the individual's current symptoms/behavior, treatment recommendations, least restrictive alternatives.

3 The prescreener and the SWVMHI person taking the call will consult to determine whether the patient needs MR Services. If so, then during normal business hours on the next working day following the admission, SWVMHI and SWVTC or CVTC and a CSS representative will confer and quickly resolve any questions as to which institution can best meet the individual's needs.

4. Once the appropriate facility has been agreed upon, the receiving facility will notify the prescreener of the referring CSB to finalize the admission.

5. The Unit Director of Admissions or designee will meet with the individual's assigned treatment team during the initial staffing of the individual in order to relate information provided through the consultation with the CSB staff. This will provide continuity of care by addressing treatment recommendations, special needs of the individual, discharge planning options, etc.

SWVMHI COMMITMENT HEARING / TREATMENT / DISCHARGE PLANNING

1 As soon as possible after admission to SWVMHI, the following parties will have a representative involved in a telephone conference call:

A) SWVMHI
B) Admitting CSS - MR Services
C) Admitting CSS - MI Services
D) SWVTC or CVTC if the individual requires MR facility services

2. The CSS prescreener or designee as approved by the CSS Mental Health Director will attend and/or participate in the commitment hearing as SWVMHI in accordance with the Client Service Management Guidelines, July 1988, Code of Virginia, 37.1 - 67.3.

3. The admitting CSB will appoint a representative who is qualified to ensure adequate representation of MH/MR issues and resources. This individual will attend and participate in the individual's Comprehensive Evaluation and Treatment Planning Conference which is held within 10 days of admission. This conference will focus on the development of a discharge plan and treatment objectives.

MR FACILITY ADMISSIONS

As soon as possible after admission to SWVTC or CVTC, the following parties will have a representative involved in a telephone conference call:

A) SWVTC or CVTC
B) Admitting CSB - MR Services
C) Admitting CSB - MI Services
D) SWVMHI if the individual requires MI facility services

2. If judicial certification is required, a CSB representative (for both MR & MI issues) will attend and/or participate in the judicial hearing in accordance with 37.7 - 65.1.

3. The admitting CSS will appoint a representative who is qualified to ensure adequate representation of MH/MR issues and resources. This will attend regular treatment team meetings.

RESOURCE ISSUES

1 In some cases the Institute and CSB working together may identify an appropriate discharge/aftercare plan but cannot implement such a plan due to a lack of resources. Assistance will be requested moving progressively upward through administrative levels at both the Institute and the CSB. Once all local options have been exhausted, the CSB and Institute will jointly request assistance from the Directors of the offices of Mental Health, Mental Retardation, (DMHMRSAS).

APPLICABILITY

This agreement will be in effect in the eight (8) CSBs served jointly by SWVMHI, SWVTC, and CVTC in Health Planning Region III

(Nov 92B)

HPR IV CONSORTIUM

COMMUNITY EMERGENCY/CRISIS INTERVENTION FOR INDIVIDUALS WITH MENTAL RETARDATION AND MENTAL ILLNESS

CENTRAL STATE HOSPITAL
PETERSBURG, VIRGINIA
May 31, 1996

I. Individuals Known to the CSB

A. CSB mental retardation and mental health directors will ensure that procedures are in place to notify the CSB's emergency/crisis intervention staff when they anticipate an individual with mental retardation may be at risk for crisis intervention.

Procedures should include sharing relevant information about the consumer, interventions that should be considered, medical information, treating psychiatrist, and, in the event of a crisis, the mental retardation professional(s) to be consulted in the case during regular and after office hours, weekends, and holidays.

B. CSB mental retardation and mental health directors will ensure that procedures are in place for CSB's emergency/crisis intervention staff when a crisis occurs without warning for an active CSB consumer who has mental retardation.

Procedures should include how to access relevant information about the consumer, CSB options for individuals with mental retardation in crisis situations and the mental retardation professional(s) to be consulted during regular and after office hours, weekends, and holidays.

Individuals Unknown to the CSB

A. CSB mental retardation and mental health directors will ensure that procedures are in place for CSB's emergency/crisis intervention staff when a crisis occurs for a person with mental retardation (or who may be perceived as having mental retardation) who is not an active CSB consumer.

Procedures should include information about CSB options for individuals with mental retardation (or who may be perceived as having mental retardation) in crisis situations and the mental retardation professional(s)

to be consulted in crisis cases during regular and after office hours, weekends and holidays.

PRACTICE EXPECTATIONS

Individuals with mental retardation and mental illness who are in crisis are reported to the CSB's emergency/crisis intervention staff.

2. Following, whenever possible, a joint face-to-face evaluation, the CSB's crisis intervention and mental retardation staff will determine whether or not the individual meets the criteria for a TDO.

3. If, as a result of the face-to-face evaluation when a mental retardation professional is not present, the individual does not meet the criteria for a TDO and appears to be able to be maintained in the community, the CSB's emergency/crisis intervention staff will notify an appropriate mental retardation professional of the case. Each CSB will identify the mental retardation professional to be contacted in situations such as this. The CSB's mental retardation staff will follow-up on the case as is appropriate.

4. If, as a result of the face-to-face evaluation, the individual does not meet the criteria for a TDO, and appears to need emergency respite care or services unavailable in the community, a CSB mental retardation professional will apply to Southside Virginia Training Center (SVTC) for immediate respite care. SVTC staff will ensure that procedures are in place to assure immediate access to emergency respite care in these situations.

5. If, as a result of a face-to-face evaluation, a TDO is issued to a private hospital or to Central State Hospital (CSH), the CSB crisis intervention staff, in cases where the individual is known to the CSB, will notify the individual's primary case manager, or, for individuals previously unknown to the CSB, an appropriate mental retardation professional of the case as soon as possible. If feasible prior to the commitment hearing, for the purpose of developing a recommendation for the least restrictive and most therapeutic alternative, the individual's primary case manager or the CSB mental retardation staff will also arrange an interdisciplinary consultation (conference call), to include CSB MR professional, CSB MH professional, CSH designee, SVTC designee, and others as appropriate.

A list of all CSB, CSH, and SVTC designees and phone numbers will be developed and shared with all relevant parties and updated at least annually. Each CSB Crisis Coordinator and SVTC will provide information to CSH, which will assume responsibility for maintaining the regional listing.

6. To the extent possible, CSB mental health and mental retardation staff will be present at the commitment hearing and present a unified recommendation for disposition.

7. The commitment hearing may result in at least four potential dispositions. These are: home/community, SVTC crisis respite, involuntary commitment to a private hospital or to CSH. Action subsequent to each of these dispositions will be as follows:

    a. Home/Community - CSB mental retardation professional assumes case management responsibility and follow-up, and accesses regional expertise at CSH, SVTC, or within the CSB system.

    b. SVTC Crisis Respite - CSB mental retardation professional initiates telephone conference call to SVTC, CSB MH professional and CSH (if individual requires psychiatric support/treatment).

    If judicial certification is required, CSB MR professional will attend and/or participate in the judicial hearing in accordance with 37.1-65.1. The CSB will assure that mental retardation staff attend regular SVTC treatment team meetings.

    c. Private Hospital - CSB MH and MR professionals jointly develop a plan to ensure active treatment.

    d. CSH - CSH will assume responsibility for ensuring that within ten days there will be an individual Comprehensive Evaluation and Treatment Planning Conference. This conference will focus on the development of a discharge plan, treatment objectives, optimum site for implementation (CSH, SVTC, or community) and time frames to implement discharge or transfer to SVTC as indicated. Conference to include CSB, MH, MR, and SVTC designees, and CSH treatment team members. Individuals with mental retardation shall be transferred to SVTC or discharged (if placement is available) as soon as their psychiatric condition is stabilized. Once consumers are stabilized they should not be maintained at CSH pending placement but should be transferred to SVTC or other appropriate facility.

APPLICABILITY

This protocol will be in effect in the eight CSBs served jointly by Central State Hospital and Southside Virginia Training Center in Health Planning Region IV and reviewed annually.

MH/MR HOSPITAL ADMISSIONS AND DISCHARGE PROTOCOL

HPR V

The intent of the Protocol is to insure that dually diagnosed (MI/MR) clients receive appropriate services for their needs. It is designed to address both MR and MH needs and to determine which facilities and/or services could best meet those needs. The goal is to bring MH and MR services together to secure and provide the best services possible for the client. The Protocol addresses the areas of crisis intervention, hospitalization, discharge planning, and MH treatment for SEVTC residents.

CRISIS INTERVENTION

It is recommended that problematic psychiatric behaviors be addressed when they first occur rather than waiting until a crisis develops. When problematic behaviors are first noted, MR case managers should address the situation and call upon any available resources to prevent the situation from escalating further.

When an MR client presents in psychiatric crisis, the emergency services screener shall consult with the MR case manager and both must agree on psychiatric hospitalization. If there is no MR case manager, a representative of MR services shall be consulted. If needed, a TDO will be obtained and a hearing held locally. If the MR case manager and the emergency services worker disagree, the case shall be presented by these workers to their next organizational level for consultation. This is a process in which time is of the essence.

HOSPITALIZATION

From the time of admission to the detention facility until the hearing, the client is to be evaluated by an independent evaluator, according to statutes. The CSB shall consult with the evaluator, SEVTC, and ESH immediately. The MR case manager and a representative from emergency services must attend the commitment hearing. If it is determined that the client requires inpatient psychiatric services, the CSB shall request a 30 day commitment. Whenever possible, commitment to a private facility should be sought, if not possible, then ESH is the commitment facility. If it is determined that the patient does not require inpatient treatment for mental illness, the disposition of the client shall be the responsibility of MR services.

DISCHARGE PLANNING

Discharge planning should not wait until the client's condition is stable. Discharge plans should be in place as soon as possible so that when the client is stable, s/he can be quickly discharged.

If the client is committed to a hospital (public or private), a community/hospital Prescription Team meeting must be held within 72 hours to formulate and discuss an effective treatment and

discharge plan. This meeting will include everyone involved with the client, ESH (or private hospital) staff, CSB MR case managers, hospital liaison, SEVTC staff and other possible placement providers. This meeting may be in the form of a conference call or other technological means.

If at this meeting admission to SEVTC is recommended, the MR case manager will prepare application materials, including a prescreening report, to be submitted to the Training Center. The case manager will request either a regular (judicially certified) admission in accordance with §37.1-65.2 or an emergency (21 day) admission in accordance with §37.1-65.2 . If the client is accepted for regular admission, the Training Center will expedite the admission process. If the client is accepted for emergency care and there is no bed available at SEVTC, the Training Center will request admission to another state facility, as outlined in the DMHMRSAS Regulations for Respite and Emergency Care Admissions to Mental Retardation Facilities. If an emergency admission is arranged at SEVTC or another facility it is the responsibility of the CSB MR services to immediately locate another service option and discharge the client within 21 days.

If placement in the community is the recommendation, CSB MR services shall be responsible for finding an appropriate facility for the client.

SEVTC RESIDENTS

When a client residing at SEVTC requires psychiatric treatment and those services cannot be accessed through a private facility, the Training Center will contact the ESH Admissions Coordinator to discuss the case and following the discussion, will contact Chesapeake emergency services to request prescreening for a commitment hearing. Any SEVTC resident who is the subject of such a hearing will be committed to ESH with the understanding that s/he will remain on the census of the Training Center on special hospitalization status.

During the time the client resides at ESH, staff from both facilities will maintain close contact regarding the client's progress and will attend discharge planning meetings, as appropriate. Therefore, the 30 day commitment requirement and the meetings described in the above sections will not be necessary because the client will return to SEVTC as soon as s/he is stable. With proper authorization, SEVTC will share information regarding the client's status with his/her case management CSB.